

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

-
21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).
./☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.
22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.
23. Certified pediatric or family nurse practitioners' services.

Provided: ☒ No limitations ☐ With limitations*

*Description provided on attachment

TN NO. MS-92-1

APR 10 1992

Supersedes Approval Date

Effective Date NOV 01 1991

TN NO. MS-91-24

HCFA ID: 7986E

Substitute per letter dated 12/19/91 "

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

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State/Territory: Nebraska

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24. Any other medical care and any other type of remedial care recognized
under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanatoria.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance
with a plan of treatment and provided by a qualified person under
supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

 provided not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

 X Provided: State Approved (Not Physician) Service Plan Allowed
 Services Outside the Home Also Allowed

 X Limitations Described on Attachment

 Not Provided.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

ABORTIONS:

Payment for abortions under the Nebraska Medical Assistance Program is limited to those abortions for which FFP is currently available.

State Plan

Trans. No. MS-81-6

Submitted 9-28-81

Approved 10-1-81

Effective 6-5-81

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

NMAP covers medical transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the appropriate staff in the Medical Services Division shall determine whether the transplant is medically necessary or non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance Program covers liver or heart transplantation when the written opinions of two physicians specializing in transplantation state that -

1. No other therapeutic alternatives exist; and
2. The death of the patient is imminent.

NMAP requires prior authorization of all transplant services before the services are provided.

NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment of complications is limited to those that are reasonably medically foreseeable.

NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant. 3.1E

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are not directly related to the transplant.

Transmittal # MS-86-14

Supercedes

Approved Oct 16, 86

Effective May 27, 86

Transmittal # MS-85-16

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

Reimbursement for inpatient hospital care of patients whose primary care needs are psychiatric in nature are limited to a hospital or distinct part of a hospital that -

1. Is maintained for the care and treatment of patients with primary psychiatric disorders;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health, or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations or American Osteopathic Association;
4. Meets the requirements for participation in Medicare for psychiatric hospitals; and
5. Has in effect a utilization review plan applicable to all Medicaid clients.

Transmittal # MS-95-13

Supersedes

Approved FEB 09 1998

Effective 7/25/95

Transmittal # MS-82-8

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - OUTPATIENT HOSPITAL SERVICES

ABORTIONS:

Payment for abortions under the Nebraska Medical Assistance Program is limited to those abortions for which FFP is currently available.

State Plan

Trans. No. MS-81-6

Submitted 9-28-81

Approved 10-01-81

Effective 6-5-81

ATTACHMENT 3.1-A
Item 2a
applies to both
categorically and
medically needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - OUTPATIENT HOSPITAL

Testing and evaluations must be performed by a licensed psychologist or under the supervision of a licensed psychologist.

Transmittal # MS-95-13

Supersedes

Approved FEB 03 1995

Effective 7/25/95

Transmittal # MS-90-4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Nebraska

ATTACHMENT 3.1-A
Page 1, Item 2 a.
applies to both
categorically and
medically needy

LIMITATIONS - OUTPATIENT HOSPITAL

Drugs, medical supplies and services not utilized in the emergency or outpatient facility are not a covered outpatient or emergency service.

State Plan
Trans. No. MS-79-13
Submitted 9-26-79
Approved 4-15-80

ATTACHMENT 3.1-a
Page 1, Item 2.b
Applies to both
categorically and
medically needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - RURAL HEALTH CLINIC SERVICES

Rural Health Clinic Services

The rural health clinic must be certified by HCFA for participation in the Medicare program. Covered services are limited to those defined in 42 CFR 440.20(b).

Transmittal # MS-91-12

Supercedes

Approved 07/12/91

Effective 04/01/91

Transmittal # MS-78-13